

Urinary Stones

PURPOSE: Collect relevant information on kidney stones

SECTION 1: Previous stones

I have not had any stones in the past/this is my first stone → SKIP THIS SECTION

Date (approximate)	Side	Treatment
_____/_____/_____ Month Year	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BOTH <input type="checkbox"/> Not sure/can't recall	<input type="checkbox"/> None – stone passed on its own <input type="checkbox"/> Shock (sound) wave treatment (ESWL) <input type="checkbox"/> Surgery (e.g. ureteroscopy) <input type="checkbox"/> Not sure/can't recall
_____/_____/_____ Month Year	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BOTH <input type="checkbox"/> Not sure/can't recall	<input type="checkbox"/> None – stone passed on its own <input type="checkbox"/> Shock (sound) wave treatment (ESWL) <input type="checkbox"/> Surgery (e.g. ureteroscopy) <input type="checkbox"/> Not sure/can't recall
_____/_____/_____ Month Year	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BOTH <input type="checkbox"/> Not sure/can't recall	<input type="checkbox"/> None – stone passed on its own <input type="checkbox"/> Shock (sound) wave treatment (ESWL) <input type="checkbox"/> Surgery (e.g. ureteroscopy) <input type="checkbox"/> Not sure/can't recall

SECTION 2: If you have RECENTLY had pain related to a kidney stone, please provide details:

I have not had any pain → SKIP THIS SECTION

Date of onset: _____ Date pain went away: _____ I am still having pain

Location of pain (check all that apply)

LEFT	RIGHT
<input type="checkbox"/> Upper back	<input type="checkbox"/> Upper back
<input type="checkbox"/> Lower back	<input type="checkbox"/> Lower back
<input type="checkbox"/> Upper abdomen	<input type="checkbox"/> Upper abdomen
<input type="checkbox"/> Lower abdomen	<input type="checkbox"/> Lower abdomen
Other: _____	Other: _____

Have you had any of the following over the past week or so?

- Visible blood in the urine (hematuria)
- Nausea and/or vomiting
- Fever documented above 38 C (100 F)
- Sensation of needing to urinate frequently

SECTION 3: Diet – Do any of the following apply to you? (check all that apply)

I don't drink very much fluid during the day

I tend to eat lots of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Spinach | <input type="checkbox"/> Nuts | <input type="checkbox"/> Salt |
| <input type="checkbox"/> Rhubarb | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Animal meat (>6 ounces/day) |
| <input type="checkbox"/> Beet roots or leaves | <input type="checkbox"/> Beans, peanuts | |

Have you had any of the following conditions in the past? (check all that apply)

- Bladder or kidney infection
- Gout
- Inflammatory bowel disease (ulcerative colitis or Crohn's disease)